MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP ( ) IE ( ) IC	**Response Timely Filed?** (x) Yes ( ) No
Requestor's Name and Address Integra Specialty Group, P.A. 517 N. Carrier Pkwy., Suite G Grand Prairie TX 75050	MDR Tracking No.: M5-05-1149-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address BOX #: 19 Fidelity & Guaranty Ins. c/o Flahive, Ogden & Latson PO Drawer 13367 Austin TX 78711	Date of Injury: Employer's Name: CBRL Group, Inc. Insurance Carrier's No.: 000537001190WC01

PART II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2, if needed)

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
2/2/04	**8/16/04**	**99204, 99213, 97010, 97012, 97124, 97032, 97035, 97110, 97140, 95833, 95851, 96004, 97750-MT, 99080-73**	**$5,528.52**	**$2,356.46**

PART III: REQUESTOR'S POSITION SUMMARY

12/14/04: Requestor seeking MDR for resolution to treatment / services rendered without reimbursement from Respondent.

PART IV: RESPONDENT'S POSITION SUMMARY

12/31/04: Respondent's response mentioned "Carrier had denied reimbursement for DOS 2/4/04 through 8/16/04 based on the fact that the treatment rendered is not medically necessary. Per peer reviews…the claimant suffered an umbilical hernia, an abdominal wall strain and a low back strain on 12/3/02. Dr…specifically notes that medical care so far removed from the DOI is not medically necessary…effects of the compensable injury had long resolved…"

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

- The TWCC-60 request was received by MDR on 12/14/04. According to 133.304, the dates of service (DOS) were denied improperly by the Respondent on TWCC-62's. The Requestor withdrew any medical necessity issues therefore the remaining DOS will be reviewed as fee issues.
  a) The following CPT Codes, according to Rule 134.202, have been supported with convincing evidence through S.O.A.P notes or reports that treatment / services were rendered for DOS 2/2/04 through 8/16/04. According to Rule 134.202 (c), Medicare participants shall apply the Medicare program reimbursement methodologies. Therefore, reimbursement is recommended as follows.
     1) 99213 x (7 DOS @ $68.24) = **$477.68**
     2) 97032 x (29 DOS @ $20.20) = **$585.80**
     3) 97035 x (4 DOS @ $15.84) = **$63.36**
     4) 97140 x (24 DOS @ $34.13) = **$819.12**
     5) 96004 x (2 DOS @ $152.75) = **$305.50**

     TOTAL: $2,251.46

b) Report, CPT code **99080-73** is reimbursed at $15.00 each according to rule 133.106(f)(1). Convincing evidence supports reports completed, therefore, reimbursement due for DOS 2/2/04, 3/2/04, 4/2/04, 5/2/04, 6/2/04,7/2/04 and 8/2/04. Amount due: (7 DOS x $15.00 =) **$105.00**.

c) CPT Code **97010** (hot/cold pack application) is a bundled service code and considered an integral part of a therapeutic procedure(s) explained in MDR newletters. Therefore, per the 2002 Medical Fee Guideline, no reimbursement is recommended.

d) CPT code **97012** is considered by Medicare to be mutually exclusive to CPT 97140. Therefore on the DOS where these codes were both billed, only CPT code 97140 was reimbursed. All the DOS in this dispute billed both CPT codes, therefore, 97012 will not be reimbursed in this Finding & Decision.

e) The CPT Code, **97110** for all DOS are not recommended for reimbursement. Review of disputes involving CPT Code 97110 by the Medical Dispute Resolution section indicate overall deficiencies in the adequacy of the documentation of this Code both with respect to the medical necessity of one-on-one therapy and documentation reflecting that these individual services were provided as billed. Moreover, the disputes indicate confusion regarding what constitutes "one-on-one." Therefore, consistent with the general obligation set forth in Section 413.016 of the Labor Code, the Medical Review Division has reviewed the matters in light all of the Commission requirements for proper documentation. The MRD declines to order payment because the SOAP notes do not clearly delineate exclusive one-on-one treatment nor did the requestor identify the severity of the injury to warrant exclusive one-to-one therapy.

f) CPT code **95833** billed on 4/7/04 and CPT code **95851** billed on DOS 4/14/04, are considered by Medicare, according to Rule 134.202 (c), to be a component procedure of the office visit, therefore the services represented by the code combination may not be paid separately, reimbursement not recommended.

PART VI: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is entitled to additional reimbursement in the amount of $2,356.46. The Division hereby **ORDERS** the insurance carrier to remit this amount plus all accrued interest due at the time of payment to the Requestor within 20-days of receipt of this Order.

Authorized Signature	Name	6 / 3 / 05 Date of Order

PART V: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, PO Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART IX: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____